No. 07-331

IN THE

Supreme Court of the United States

SUN LIFE ASSURANCE COMPANY OF CANADA,

Petitioner,

v.

MARGARET T. WHITE,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF *AMICUS CURIAE* THE AMERICAN COUNCIL OF LIFE INSURERS IN SUPPORT OF SUN LIFE ASSURANCE COMPANY OF CANADA'S PETITION FOR A WRIT OF CERTIORARI

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TABLE OF CONTENTS

	Page
TABLE OF CITED AUTHORITIES	iii
INTEREST OF *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	3
REASONS FOR GRANTING THE petition ...	5
A. The Disputed Policy Provision Is A Standard Policy Provision Uniformly Mandated By The States And Traditionally Used Within The Insurance Industry.	5
B. A Conflict Exists Among The Circuit Courts Of Appeal Regarding Enforcement Under ERISA Of State-Mandated Insurance Policy Provisions That Require A Limitations Period To Commence When Proof Of Claim Is Due.	8
1. The Majority of Circuits Enforce the Limitations Provision Where Reasonable as Applied to the Particular Facts of the Case.	9
2. The Minority Of Circuits Hold That Proof Of Loss Accrual Clauses Are Not Enforceable In The ERISA	

Contents

Page

Context, But Adopt Different Standards For The Appropriate Accrual Date. 10

C. The Conflict Among The Circuits Undermines Basic ERISA Policies And Adversely Affects Employee Benefit Plans Funded Through Insurance. 12

1. Enforceability of Contractual Limitations and Accrual Provisions is Fundamental to ERISA Plans and Insurance Policies. 12

2. The Conflict Undermines the National Uniform Regulation Intended by ERISA, and Consequently Increases the Cost to Employers of Providing Benefit Plans. 13

D. State-Mandated Limitations And Accrual Policy Provisions Should Be Enforced Under ERISA. 15

CONCLUSION 18

APPENDIX 1a

TABLE OF CITED AUTHORITIES

Page

Cases:

Black & Decker Disability Plan v. Nord, 538 U.S. 822 (2003) 13

Blaske v. Unum Life Insurance Company of America, 131 F.3d 763 (8th Cir. 1997), *cert. denied*, 525 U.S. 812 (1998) 9, 17

Clark v. NBD Bank, NA, 3 Fed. Appx. 500 (6th Cir. 2001) 10

Doe v. Blue Cross & Blue Shield United of Wisconsin, 112 F.3d 869 (7th Cir. 1997) 9, 17

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 4, 14

Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan, 426 F.3d 330 (5th Cir. 2005) 9

Miller v. Fortis Benefits Ins. Co., 475 F.3d 516 (3d Cir. 2007) 10, 11

Moore v. Berg. Enters., 1999 U.S. App. LEXIS 30481 (10th Cir. 1999) 10

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) 14

Cited Authorities

Page

Order of United Commercial Travelers v. Wolfe, 331 U.S. 586 (1947) 3, 7, 8

Price v. Provident Life & Accident Ins. Co., 2 F.3d 986 (9th Cir. 1993) 10, 11

Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Insurance Program, 222 F.3d 643 (9th Cir. 2000) 11, 12

Statutes:

29 U.S.C. § 1001, *et seq.* 1

29 U.S.C. § 1102(a)(1) 12

29 U.S.C. § 1104(a) 12

29 U.S.C. § 1132(a)(1)(B) 8

29 U.S.C. § 1132(a)(3) 12

N.C. Gen. Stat. § 58-51-15 ..... 5, 6

N.C. Gen. Stat. § 58-51-15(a)(11) 5

Utah Code Ann. § 31A-21-313 6

Cited Authorities

Page

Regulations:

29 C.F.R. § 2560.503-1(f)(3) 16

29 C.F.R. §§ 2560.503-1(f)(4) 17

29 C.F.R. § 2560.503-1(h)(3)(i) 17

29 C.F.R. § 2560.503-1(h)(4) 17

29 C.F.R. § 2560.503-1(i)(l)(i) 16

29 C.F.R. § 2560.503-1(i)(3)(i) 16

Other Authorities:

H.R. Rep. No. 93-533, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647 13

I NAIC, "Group Health Insurance Standards Model Act," *Model Laws, Regulations and Guidelines* at 100-1, § 8(N) (2007) 5

II NAIC, "Uniform Individual Accident and Sickness Policy Provision Law," *Model Laws, Regulations and Guidelines* at 180-1, § 3(a)(12) (2007) 5

Uniform Individual Policy Provisions Law Model Bill of 1950, § 3(A)(11), *reprinted in* William F. Meyer, *Life and Health Insurance Law* app. A (1971) 6

INTEREST OF *AMICUS CURIAE*

The American Council of Life Insurers ("ACLI")[1] is the largest life insurance trade association in the United States, representing the interests of 373 legal reserve life insurers operating in the United States. ACLI member companies are the leading providers of financial and retirement security products covering individual and group markets. They provide life, disability income and long-term care insurance. In the United States, ACLI members account for 93 percent of the life insurance industry's total assets, 91 percent of life insurance premiums, and 95 percent of annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

Resolution of the question presented — whether an unambiguous limitations period set forth in an ERISA-governed disability insurance policy is unenforceable solely because it requires that the limitations period

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1. Pursuant to Rule 37.6, the ACLI's counsel of record hereby certifies that this brief was authored in whole by Barnes & Thornburg LLP, and that no individual or entity other than the ACLI has contributed monetarily to the preparation of this brief. Pursuant to Rule 37.3(a), ACLI states that both petitioner and respondent have consented to the filing of this brief. Their respective letters of consent are being filed concurrently herewith.

commence when proof of claim is due — presents significant issues for employee benefit plans and the insurance industry as a whole and will have legal and practical ramifications far beyond the disposition of this particular case. The policy provision at issue is a standard limitations provision that is not only mandatory in North Carolina (where this case arises), but also in nearly every other state. The accrual clause set forth within the provision, pursuant to which the limitations period commences at the time proof of claim is due, also has long been the traditional practice within the insurance industry.

The decision below broadens the current conflict among the circuits respecting enforcement of such limitations provisions when set forth in policies that fund an ERISA plan. Given the extensive involvement of ACLI's members in the employee benefits field regulated by ERISA, ACLI is well-positioned to address the practical impact of, and the significant adverse consequences stemming from, the decision below and the conflict among the circuits on this question for insurers and the employers who fund their benefit plans through the purchase of insurance. Such conflict undermines the uniform regulatory regime Congress intended in enacting ERISA, alters unambiguous policy terms mandated by state law and agreed to by the parties, and presents particular issues for plans operating across multiple state jurisdictions. ACLI is uniquely positioned to explain the practical ramifications of this conflict upon employer-sponsored benefit plans, and hence the need for the Court to resolve this conflict.

SUMMARY OF ARGUMENT

Enforceability of a policy's limitations provision is a fundamental issue affecting all types of ERISA plans funded by insurance policies, including employer-sponsored life, health and disability benefit plans. The question presented is of critical importance because insurance laws in nearly every state require that life, health and disability insurance policies include a provision which specifies that the limitations period commences at the time proof of claim is due under the policy, which is consistent with long-standing industry practice.

Furthermore, ERISA and federal law afford plan drafters broad leeway in specifying such terms. ERISA is silent with respect to the limitations period applicable to suits for denied benefits. When statutes do not specify a limitations period, the Court's precedent provides that a contractual limitations period is enforceable where it provides a reasonable time for the parties to file suit. *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586 (1947). The "reasonableness" of the limitations provision at issue and its accrual clause is evidenced by its incorporation into the insurance laws of nearly every state as well as model laws drafted by the National Association of Insurance Commissioners ("NAIC"). This reflects a broad consensus that the standard limitations provision at issue herein preserves an appropriate time within which insureds and plan participants can pursue court action while also guarding against the difficulties and burdens that can arise in litigating stale claims.

Despite the near uniform adoption of this limitations provision in state insurance law, there is a conflict among

the federal circuit courts of appeal as to whether such provisions are enforceable under ERISA insofar as the accrual clause commences running of the limitations period at the time proof of loss is due. The decision of the Fourth Circuit below further exacerbates this conflict and creates a proverbial "Catch-22": state insurance laws mandate that insurance policies include such limitations provisions, but those very same provisions are unenforceable (at least in three circuits) when such policies fund an ERISA plan.

The existing conflict among the circuits is particularly problematic because it undermines Congress' key objective in enacting ERISA – to establish a "uniform administrative scheme" for ERISA-covered benefit plans and a uniform body of federal common law for enforcement of such plans. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress sought to establish this uniformity as part of its effort to encourage employers to establish benefit plans by eliminating the difficulties presented by, and increased costs resulting from, a patchwork of conflicting state and local laws. Herein, state insurance law is essentially uniform regarding proof of claim accrual clauses, but federal case law is creating the lack of uniformity. This lack of uniformity among the circuits significantly impacts the manner and cost of operating employer-sponsored benefit plans, especially for those offering such plans in multiple jurisdictions.

REASONS FOR GRANTING THE PETITION

A. The Disputed Policy Provision Is A Standard Policy Provision Uniformly Mandated By The States And Traditionally Used Within The Insurance Industry

The limitations provision at issue in this case provides in relevant part that no legal action may be brought to recover on the policy "more than 3 years after the time Proof of Claim is required." Pet. at 4. The limitations provision was mandated by North Carolina General Statutes § 58-51-15, which requires in relevant part that accident and health policies issued or delivered in that state contain a provision to the effect that no action at law or equity shall be brought "after the expiration of three years after the time written proof of loss is required to be furnished." N.C. Gen. Stat. § 58-51-15(a)(11). This statute is consistent with the model insurance laws drafted by the National Association of Insurance Commissioners. *See* I NAIC, "Group Health Insurance Standards Model Act," *Model Laws, Regulations and Guidelines* at 100-1, § 8(N) (2007); II NAIC, "Uniform Individual Accident and Sickness Policy Provision Law," *Model Laws, Regulations and Guidelines* at 180-1, § 3(a)(12) (2007).

Nearly every state (and the District of Columbia) requires that health and/or disability insurance policies sold or delivered within the state contain a limitations provision which commences running of the limitations period at the time proof of loss is required under the

policy,[2] consistent with the model laws and the policy provision at issue in this case. Only the state of Utah does not specify by statute that policies contain a limitations provision specifying that the limitations period begins to run at the time proof of loss is due. Instead, Utah has mandated by statute that any action on a written policy or contract of first party insurance must be commenced within three years after "inception of the loss." Utah Code Ann. § 31A-21-313.

The limitations provision and accrual clause typically mandated by the states is also reflective of long-standing practice within the industry. The limitations provision itself dates at least to NAIC's Uniform Individual Policy Provisions Law Model Bill of 1950, which required that policies contain a limitations provision identical to that currently set forth in North Carolina General Statutes § 58-51-15.[3] Use of the accrual clause in the insurance

2. A complete list of legal citations for the state laws mandating incorporation of limitations provisions that commence the limitation period when proof of loss is due is set forth in Appendix A hereto. While a few of the states specify a limitations period longer than three years, all contain a accrual clause which mandate that the period commences when proof of loss is due under the policy.

3. The 1950 model law required that policies contain the following provision:

> LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

See Uniform Individual Policy Provisions Law Model Bill of 1950, § 3(A)(11), *reprinted in* William F. Meyer, *Life and Health Insurance Law* app. A (1971).

industry predates the 1950 model law. For example, as the Court observed in *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586 (1947), South Dakota law at that time mandated that such a limitations provision be included in all health or accident policies, and further described the provision as "a standard provision." *Id.* at 612 & n. 23 ("action must be brought within two years from the expiration of the time within which proof of loss is required by the policy" (citing s 3(14), c. 229, S.D.L. 1919, at page 235)).

The fact that states uniformly require that policies contain the limitations provision underscores that crucial role that it plays in the administration of insurance policies and the ERISA plans they fund. As with any specified limitations period, the purpose is to address the difficulties associated with litigating stale claims. The problem presented by stale claims takes on heightened significance in the health and disability context, however, where a plan participant's disability or health status may shift significantly over time. Evidence of the participant's contemporaneous condition can prove difficult to reconstruct. Additionally, subsequent changes in the participant's medical status, whether such change be improvement or deterioration, can potentially distort interpretation of the contemporaneous evidence of the participant's condition at the time the claim is made.

Overall, the limitations provision balances both the concern against litigating stale claims and the concern that insureds or plan participants be provided with an adequate period of time in which to press their claims. The proof of claim accrual clause addresses the former by linking the limitations period to the time when evidence relevant to the claim can most easily be

obtained. The length of the period specified — in North Carolina (and in most states) three years — for proceeding with an action is set to provide an adequate time both for an ultimate decision to be made upon a claim and for the participant to thereafter pursue court action.

B. A Conflict Exists Among The Circuit Courts Of Appeal Regarding Enforcement Under ERISA Of State-Mandated Insurance Policy Provisions That Require A Limitations Period To Commence When Proof Of Claim Is Due.

ERISA does not specify a limitations period applicable to ERISA suits for denied benefits under 29 U.S.C. § 1132(a)(1)(B). Lower courts have applied "the most analogous" state limitations period, unless the ERISA plan sets forth a limitations period. Where the ERISA plan specifies a limitations period, courts have enforced the period where the period is reasonable, in accordance with *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 608 (1947) (holding that contractual limitations periods are binding where the period is reasonable).

In the context of insured plans, as discussed *supra*, state insurance law typically mandates the limitations provision that must be included in the policies funding the plans as one of several standard provisions state law requires to be included in policies. The specific accrual clause set forth therein which is the subject of the Petition also is a standard and uniform provision of insurance disability income, health and life policies funding ERISA plans.

Eight circuits have considered whether a policy limitations provision which specifies that the period commences at the time proof of claim is due is enforceable under ERISA. As discussed below, the majority of these eight circuits have applied the provisions where such application is "reasonable." The minority of circuits which do not enforce such limitations provisions in the ERISA context conceptually correlates the accrual date with the denial of benefits (or at least notice thereof), but each sets forth a different formulation of the appropriate accrual date.

1. The Majority of Circuits Enforce the Limitations Provision Where Reasonable as Applied to the Particular Facts of the Case.

Five of the eight circuits have enforced limitations provisions containing such accrual clauses, provided the time remaining for a participant to file suit after the claim and internal appeal process is completed is reasonable under the particular facts of the case. The Fifth, Seventh and Eighth Circuits all have enforced accrual clauses that run from events other than the denial of benefits. *See Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan*, 426 F.3d 330, 337-38 (5th Cir. 2005) (enforcing three-year limitations period that began to run from date proof of loss was due); *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 875 (7th Cir. 1997) (enforcing thirty-nine month limitations period that began to run from the date of the services for which benefits were sought); *Blaske v. Unum Life Insurance Company of America*, 131 F.3d 763, 764 (8th Cir. 1997), *cert. denied*, 525 U.S. 812 (1998) (enforcing policy limitations provision that began the period at the time that proof of claim was required).

In unpublished decisions, the Sixth and Tenth Circuits have also enforced such provisions. *See Clark v. NBD Bank, NA*, 3 Fed. Appx. 500 (6th Cir. 2001) (enforcing limitations period which commenced at the time "written proof of loss is required to be furnished"); *Moore v. Berg. Enters.*, 1999 U.S. App. LEXIS 30481 (10th Cir. 1999) (enforcing three year limitations period which commenced on the date proof of loss was required).

In assessing the reasonableness of the contractual limitations provisions, these five circuits have implicitly recognized that the specified accrual date is not a *de facto* litmus test for the reasonableness of the limitations period. Rather, these circuits have applied both the accrual date and the specified length of the limitations period in determining whether the provision as applied to the facts of the particular case was reasonable overall and afforded the participant a reasonable opportunity in which to file suit after the plan's internal administrative remedies had been exhausted.

2. The Minority Of Circuits Hold That Proof Of Loss Accrual Clauses Are Not Enforceable In The ERISA Context, But Adopt Different Standards For The Appropriate Accrual Date.

In contrast, the Fourth Circuit herein joins the Third and Ninth Circuits in essentially holding that an accrual clause that runs from the date proof of loss is required to be furnished is unenforceable *per se* under ERISA. *See Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520-521 (3d Cir. 2007); *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986 (9th Cir. 1993). While these circuits acknowledge that the parties can specify the length of the limitations periods, they have held that the parties'

freedom to do so under federal law does not extend to the accrual date itself.

Although each of these three circuits has rejected the date proof of claim is due as an appropriate accrual date, none agrees on what the appropriate accrual date actually is. The Fourth Circuit herein established a blanket rule that the appropriate accrual date is the date that benefits are denied. 488 F.3d at 247 (holding that "[ERISA's] interlocking remedial structure does not permit an ERISA plan to start the clock ticking on civil claims while the plan is still considering internal appeals").

The Third Circuit has determined that the limitations period begins to run once there is a "clear repudiation" of a benefit claim. *Miller*, 475 F.3d at 522-23. Pursuant to the Third Circuit's formulation, a formal denial of benefits is not required to start the limitations period running. Rather, the limitations period commences once there is a repudiation of the benefit claim and that repudiation is both clear and made known to the beneficiary. *Id.* at 521.

The Ninth Circuit has adopted yet another accrual rule, which provides that the limitations period begins to run when the claimant knows, or has reason to know of the denial. *Price*, 2 F.3d at 988. Significantly, Ninth Circuit law respecting the parties' ability to specify even the length of the limitations period in the ERISA context is at best unclear. In *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Insurance Program*, 222 F.3d 643 (9th Cir. 2000), the *en banc* Ninth Circuit held that California's four-year statute of limitations for suits on written contracts applies to an ERISA action for denial

of benefits, notwithstanding the fact that the policy required that any action to recover benefits must be commenced within "three years after the time written proof of loss is required." 222 F.3d at 648, 650. After determining that the action was not barred by the four-year statute of limitations, the Ninth Circuit nonetheless remanded the case for a determination as to whether the claimant complied with the policy's contractual limitations provision.

C. The Conflict Among The Circuits Undermines Basic ERISA Policies And Adversely Affects Employee Benefit Plans Funded Through Insurance.

1. Enforceability of Contractual Limitations and Accrual Provisions is Fundamental to ERISA Plans and Insurance Policies.

It is important for the efficient operation of employer-sponsored benefit plans covered by ERISA that this Court resolve the conflict among the circuits regarding enforceability of limitations provisions that commence to run at the time proof of loss is due. Under ERISA's statutory and regulatory scheme, enforcement of plan terms is paramount. ERISA requires that plans be "established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). Plan fiduciaries are required to discharge their duties "in accordance with the documents and instruments governing the plan." *Id.* § 1104(a). Plan participants, beneficiaries and fiduciaries all are provided specific causes of action to enforce written plan terms. *Id.* § 1132(a)(1)(B) (providing plan participants and beneficiaries a cause of action to recover benefits due and enforce their rights "under the terms of the plan"); *id.* § 1132(a)(3) (providing plan

participants, beneficiaries and fiduciaries a cause of action for injunctive and other appropriate equitable relief to enforce or redress violations "of the terms of the plan").

Plan terms regarding applicable limitations and accrual provisions are no less paramount than other plan terms. As specified above, they play a crucial role in safeguarding against the challenges presented in litigating stale claims. The Court has previously recognized that ERISA affords employers "large leeway to design . . . plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Where employers choose to fund ERISA plans through the purchase of insurance, such "leeway" must encompass incorporation of standard policy provisions mandated by state insurance law.

2. The Conflict Undermines the National Uniform Regulation Intended by ERISA, and Consequently Increases the Cost to Employers of Providing Benefit Plans.

Conflicting interpretations of federal law are disfavored generally and they are particularly problematic in the ERISA context. The circuit conflict regarding enforceability of limitations provisions and accrual clauses undermines the public policies underlying ERISA. In enacting ERISA, Congress was mindful not only of the need to establish certain minimum standards to protect the rights of employees, but also of the fact that benefit plans are voluntary on the part of employers. H.R. Rep. No. 93-533, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647. One of ERISA's bedrock purposes therefore is to encourage the

formation of employee benefit plans. 29 U.S.C. § 1001b(c)(2). Congress accordingly sought to minimize disincentives to the establishment of such plans and to facilitate their establishment at a reasonable cost.

The basic thrust of ERISA is to avoid multiplicity of regulation in order to permit uniform national administration of employee benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995). For over 30 years, ERISA's uniform regulation of employee benefit plans has fostered and protected the development of a system that extends crucial employee benefits to a vast swath of the nation's working population. ERISA has encouraged employers to take on the challenge of sponsoring benefit plans to provide employees and other beneficiaries with substantial financial protection from the high cost of health care, from the financial risk of a disabling illness or injury, and for financial security in retirement. A key component of ERISA's success in expanding and enhancing employee benefits is the protection it affords plan sponsors, which frequently have employees and operations in many states, from the burdens of having to comply with multiple regulatory regimes. As this Court has noted, conflicting requirements make benefit administration more difficult and inefficient. When inefficiencies or difficulties are introduced into the benefit administration system, employers may decide to reduce the level of benefits offered, or to cease offering the benefits entirely. *Fort Halifax Packing Co.*, 482 U.S. at 11.

Herein, state insurance law is essentially uniform regarding proof of claim accrual clauses, as nearly every state requires their incorporation into insurance policies.

Federal case law is creating a lack of uniformity. The disruption to a uniform system of administration is no less problematic when the lack of uniformity stems from conflicting interpretations of federal law, than when it results from conflicting state laws and regulatory requirements. In either context, unless the most stringent of the conflicting requirements is adhered to, the plan and claims procedures must be tailored to the particular jurisdiction in which the claim arises. Both situations increase the cost of providing benefits for all participants, and both present particular challenges for plans operating in multiple jurisdictions.

D. State-Mandated Limitations And Accrual Policy Provisions Should Be Enforced Under ERISA.

ACLI respectfully submits that state-mandated limitations and accrual provisions should be enforced under ERISA. As the dissent concluded below, the policy's limitations provision is "eminently reasonable" and tying the limitations period to the date on which proof of claim is due serves the important function of ensuring that a civil action is not "too temporally removed from the events underlying it." 488 F.3d at 259-60, 263. The reasonableness of the disputed limitations provision is amply demonstrated by the fact that nearly every state mandates that it be included in insurance policies, and by the fact that since at least 1950, it has been incorporated into the model insurance laws adopted by the NAIC.

The Fourth Circuit's decision below failed to acknowledge both the fact that North Carolina law requires that the limitations provision be included in the

policy and the wide-spread adoption of the provision by nearly every other state. Throughout its decision, the Fourth Circuit refers to the limitations provision as "Sun Life's accrual provision," as though Petitioner independently conceived and voluntarily crafted the provision for inclusion in the policy. For this reason, the Fourth Circuit's concern that insurers would craft limitations periods of such short duration that they could easily consume the minimum time periods required for claims processing and the plan's internal appeal process under ERISA's regulatory requirements is overstated. While state insurance law may permit insurers to provide limitations periods of longer duration than the minimum required by state law, they cannot shorten it. Furthermore, even if the limitations period were not mandated by state law, any such provision that established a shorter limitation period than the minimum period required under ERISA for claims processing and internal appeal would be facially unreasonable.

The Fourth Circuit's conclusion that enforcing the limitations provision at issue would create an incentive for insurers to delay issuing a decision until the policy's limitations period has run is equally overstated. ERISA's implementing regulations sets forth certain time limits for a plan's initial determination on the claim as well as on any internal appeal, and also minimum time period for a claimant to file an internal appeal. *See* 29 C.F.R. § 2560.503-1(f)(3) (limiting the time in which the plan may take in its initial consideration of the claim to 45 days from the date of filing of the claim, with two 30-day extensions allowed when needed); *id.* §§ 2560.503-1(i)(l)(i), 2560.503-1(i)(3)(i) (limiting the time in which the plan may take in considering an internal appeal to

45 days from the filing of the appeal and providing for one 45-day extension); *id.* §§ 2560.503-1(h)(4), 2560.503-1(h)(3)(i) (requiring that plan afford a claimant with at least 180 days to appeal an initial benefits determination). These time limits are intended to provide a prompt and timely resolution of the benefit claim.

Even allowing for the fact that ERISA's regulations also provide that in certain circumstances these time limits can be tolled,[4] the three-year period mandated by North Carolina law (and that of nearly every other state) provides ample time for required exhaustion of the plan's internal appeals process prior to the claimant's filing suit in the vast majority of cases, even in those cases where the appeals process is somewhat protracted. *See, e.g.*, *White*, 488 F.3d at 244-45 (benefit claim submitted on May 5, 2000; internal appeal denied March 28, 2001); *Blaske*, 131 F.3d at 763-764 (proof of claim filed in February of 1995; internal appeals process concluded and suit filed on October 15, 1995); *Doe*, 112 F.3d at 873 (psychiatric treatment first sought in December 1989; internal appeals process concluded on September 25, 1991). Furthermore, in those limited cases where the peculiar facts of a case result in an unusually protracted claims decision process, equitable doctrines such as tolling and estoppel may forestall strict application of the limitations provision.

4. *See* 29 C.F.R. § 2560.503-1(f)(4) (providing that when plan extends claims period to seek additional information needed to resolve claim, the regulatory period is tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information). It is significant to note, however, that the length of time the regulatory time period is tolled is within the control of the claimant, not the plan or insurer. The more promptly the claimant responds to the request for additional information, the shorter the duration of the claims and appeals process.

CONCLUSION

ACLI respectfully requests that the Court grant Sun Life Assurance Company's petition for a writ of certiorari.

Respectfully submitted,

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APPENDIX

APPENDIX A

Ala. Code §§ 27-19-14, 27-20-5(7); Alaska Stat. § 21.54.030(7); Ariz. Rev. Stat. §§ 20-1355, 20-1405; Ark. Code Ann. §§ 23-85-116, 23-86-102(c)(7); Cal. Ins. Code § 10350.11; Colo. Rev. Stat. §§ 10-16-202(12), 10-16-214(3)(a)(XIV); Conn. Gen. Stat. § 38a-483(a)(11); Del. Code Ann. tit. 18, §§ 3315, 3526, 3541(7); D.C. Code Ann. § 31-4712(c)(1)(K); Fla. Stat. §§ 627.616, 627.657(2); Ga. Code Ann. § 33-29-3(b)(11); Haw. Rev. Stat. §§ 431:10A-105(11), 431:10A-203; Idaho Code §§ 41-2115, 41-2207(7); 215 Ill. Comp. Stat. 5/357.12; Ind. Code §§ 27-8-5-3(a)(11), 27-8-5-15(b)(7); Iowa Code § 514A.3(1)(k); Kan. Stat. Ann. § 40-2203(A)(11); Ky. Rev. Stat. Ann. §§ 304.17-150, 304.18-070(7); La. Rev. Stat. Ann. § 22:213(A)(11); Me. Rev. Stat. Ann. tit. 24-A, §§ 2715, 2828; Md. Code Ann. Ins. § 15-217; Mass. Gen. Laws ch. 175 § 108(3)(a)(11); Mich. Comp. Laws §§ 500.3422, 500.3610; Minn. Stat. §§ 62A.04(2)(11), 62A.10; Miss. Code Ann. § 83-9-5(1)(k); Mo. Rev. Stat. §§ 376.426(14), 376.777(1)(11); Mont. Code Ann. §§ 33-22-214, 33-22--602(7); Neb. Rev. Stat. § 44-710.03(11); Nev. Rev. Stat. §§ 689A.150, 689B.080(9); N.H. Rev. Stat. Ann. §§ 415:6(I)(11), 415:18(I)(n); N.J. Stat. Ann. §§ 17B:26-14, 17B:27-46; N.M. Stat. Ann. §§ 59A-22-14, 59A-23-4(A); N.Y. Ins. Law §§ 3216(d)(1)(K), 3221(a)(14); N.C. Gen. Stat. § 58-51-15(a)(11); N.D. Cent. Code §§ 26.1-36-04(1)(m), 26.1-36-05(14); Ohio Rev. Code Ann. § 3923.04(K); Okla. Stat. tit. 36, §§ 4405(A)(11), 4505; Or. Rev. Stat. § 743.441; 40 Pa. Cons. Stat. §§ 753(A)(1), 756.3; R.I. Gen. Laws § 27-18-3(a)(11); S.C. Code Ann. § 38-71-735(m); S.D. Codified Laws § 58-18-27; Tenn. Code Ann. § 56-26-108(11); Tex. Ins. Code Ann. § 1251.116; Vt. Stat. Ann. tit. 8, §§ 4065(11), 4080; Va. Code Ann. §§ 38.2-3503, 38.2-3504; Wash. Rev. Code §§ 48.20.142, 48.21.050; Wis. Stat. § 631.83(1)(b); W. Va. Code §§ 33-15-4(k), 33-16-3(d); Wyo. Stat. Ann. §§ 26-18-115, 26-19-107(a)(vii).